

# Interaction of Competition and Regulation in Affecting Product Quality in Medical Services

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# Purpose of Paper

- A mostly theoretical discussion of how product quality is determined (for medical care and other things) in markets with varying degrees of competition.
- The primary regulatory device discussed: imposed “financial incentives” for improved product quality or outcomes
- Some discussion (added here) of the role of price regulation.

# The Benchmark Model: Rosen Equilibrium

- Assume: Competitive markets with heterogeneous consumers.
- Some fixed cost to each “level” of quality.
- There will be a variety of firms producing various levels of quality, and consumers will distribute themselves across firms based on demands for quality.
- Outcome is efficient: minimum cost given quality; people choose that level of quality at which marginal value of quality equals marginal cost of quality

# The Optimal Equilibrium and Public Policy

- In equilibrium, quality is not maximized and most people do not get the highest quality in the market: some defects, some shortfall from “longest life” or highest quality. We usually don’t mind.
- This type of equilibrium is inconsistent with health policy rhetoric emphasizing quality. We don’t want to settle for good enough but it would be foolish to pay for the best. There eventually is a tradeoff between cost or price and quality.

# Varying Competition and Quality

- How will quality change if competition is reduced?
- Answer: depends on relative sizes of price elasticity of demand and quality elasticity.
- Reducing quality reduces both elasticities, but is the relative change in them that matters. This is not known.
- If demand is more price than quality elastic, quality falls less or not at all under monopoly, but price rises a lot. And vice versa.

# Varying Competition and Quality II

- Now suppose that price was formerly regulated or prevented from being varied: Anti-selective contracting rules of Medicare fee schedule.
- Change those rules.
- Prediction: quality will fall and price will fall in *both* competitive and monopoly settings.

# Slipping into the Interior: Will firms produce low quality at high cost?

- For profit maximizing firms, this should not happen—regardless of the extent of competition or the imperfection of consumer information (as long as consumers know at least something about quality).
- Less “survival incentive” under monopoly, but why should that matter? Separation of ownership and control?
- With non-profits, this could happen if waste is valued by the organization (but not otherwise).
- So what’s our problem?

# Imperfect Information about Quality: Some Grounds for Optimism

- No reason to expect optimal equilibrium under competition. Presumably quality falls under competition or monopoly.
- But suppose some consumers are well informed. They can discipline the market and provide spillovers to uninformed: “I’ll have what the expert is having.”
- If information is true but incomplete, skeptical consumers may still achieve good outcomes: “pick the best and avoid the rest,” watch for evidence of selection

# Incentives for Quality in Competitive Markets

- In most markets, higher quality is its own reward: consumers flock to better sellers.
- Implication: a hospital that loses revenue when it improves outcomes should recoup losses with higher volume as long as pricing is reasonable (i.e., fixing up mistakes is not more profitable than extra volume at decent quality).
- So do we need/would the market choose to have explicit quality reward incentive programs, a la Leapfrog?

# Need for “extra” incentives under competition depends on information

- Only consumer/patient knows: consumer rewards with a “tip.” Not relevant to health care in US (so far).
- The market knows high quality: no need for extra incentives.
- The health plan knows but the market does not: plan sets incentive program in place.
- But is the third case an empty set?

# Need for “extra” incentives in other settings

- If a larger payer sets fixed but wrong reimbursement rates, it will not be rewarding quality and should add programs to do so. OK for Big Medicare, but this step is required only because first step was a mistake (though for good reasons).
- Such extra incentives may be chosen by private plans in markets with provider market power. So does the existence of incentives provide evidence of provider monopoly?